

Multidisciplinary rehabilitation treatment or cognitive behavioural therapy for patients with chronic fatigue syndrome

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Valorisation

INTRODUCTION

‘How can I overcome my fatigue?’, ‘What is the best treatment for my illness?’, and ‘Where can I get this treatment?’ are frequently asked questions from patients with CFS. As mentioned in the introduction of this thesis different treatments exist but patients and referrers are mainly interested in the best treatment. Although effectiveness studies have been done before, a comparison of different treatments is less common. This effectiveness study is aimed at studying which of two compared treatments is the most effective in reducing fatigue and increasing quality of life. This thesis presents not only the scientific value of the effectiveness of two different treatments for patients with CFS. In this chapter, also the societal value, i.e. the valorisation will be presented. Valorisation is transferring scientific knowledge to for example healthcare organizations, by making knowledge available and suitable for economic and social exploitation. It is the translation of knowledge into products, services, processes or new business. This chapter presents how the scientific knowledge can be transferred and utilized in society. At first, the relevance for patients and their families, therapists, medical specialists and health insurance companies, will be presented, followed by the examples of innovative activities and products.

RELEVANCE OF THE FINDINGS

Effectiveness and cost-effectiveness

Effectiveness studies provide scientific evidence on how effective treatments are. The results of this study reveal that in the long run MRT is more effective in reducing fatigue compared to CBT. This may facilitate the choice of treatment for the patient and the referrer. Unfortunately, the choice of treatment is not only depending on the effectiveness of treatment. Treatment should be available in the direct environment of a patient’s home. Sometimes patients have to travel long distances to receive treatment. Long traveling hours might change the effectiveness of treatment since travelling is often an energy consuming activity. Implementation of MRT in more rehabilitation centres is therefore advised. Furthermore, health insurance companies are more willing to reimburse treatments that are proven both effective and less expensive, which facilitates the implementation of treatment in more rehabilitation centres or other healthcare organizations, making treatment available for more patients.

Differences between active and passive patients

To improve treatment it is worthwhile studying differences in patient (sub)groups in order to decide whether or not to tailor treatments on the basis of these differences to

improve effectiveness. A clear difference in actual and perceived physical functioning between relatively active and passive patients with CVS as judged by their therapists could not be found. However, this trial was the first to study differences in activity patterns between subgroups of patients classified by their therapists.

Expectancy and credibility

To further improve treatment effectiveness it is valuable to study factors influencing this effectiveness. Reading this study can increase the awareness of therapists and specialists on how expectations can influence treatment outcome. It might stimulate other researchers to study the impact of expectations before treatment. Increasing our insight in these influences can be important for decision making of treatment choice and for the communication between therapists and patients.

INNOVATIVE ACTIVITIES AND PRODUCTS

Before the start of the study Revant, Rehabilitation Centre Breda was the only rehabilitation centre offering treatments for patients with CFS in the southern districts of the Netherlands. During the preparation of the trial, rehabilitation teams of four different rehabilitation centres received training to deliver the interventions of the MRT protocol and psychologists received training to deliver CBT. Unfortunately, after the trial was ended, some rehabilitation centres have chosen not to include the MRT for patients with CFS in their standard care supply. At this moment many patients with chronic pain are referred to a limited number of rehabilitation centres resulting in long waiting lists. Since MRT for patients with CFS is often given by the same therapists who also deliver chronic pain treatment, the number of patients on the waiting lists will increase even further if patients with CFS are included in the standard care supply of the rehabilitation centre. Some rehabilitation centres have chosen to deliver the treatments but will not promote the treatment as this might increase these waiting lists so that they would not be able to start treatment within predefined normative waiting time (the so called 'Treeknormen'). These norms are time-guidelines defined by health insurance companies and healthcare suppliers. They contain a time period in which patients should receive healthcare if needed. Furthermore, the health insurance companies use fixed budgets for each rehabilitation centre. Introducing a new patient-group will interfere with the present groups, since the introduction of a new patient-group asks for redistribution of the budget. This makes it hard to introduce new patient-groups in rehabilitation settings. It is therefore recommended that health insurance companies increase the budget for rehabilitation centres that are willing to introduce a new evidence based rehabilitation program for patients with CFS. When increasing the number of centres to adopt the program, it is important to train the therapists to deliver the evaluated proto-

col as described in this thesis. Courses and supervision meetings should be organized to train the teams in delivering MRT. By training more therapists, patients with CFS can be spread over different locations and lower the burden on the waiting lists. Different CBT centres are already training CBT therapists to deliver CBT for patients with CFS in order to decrease the number of patients on their waiting lists. Less common is the training for MRT therapists. Before the trial, protocols of MRT and courses for MRT therapist were already well described and can now be used to train other rehabilitation teams. Training can increase the knowledge regarding CFS and treatment of CFS. Although plans for such a course are not yet realized, this can be a future product of this study. If more healthcare organizations are familiar with MRT, more patients can benefit from this effective approach. For the patients, traveling time to the nearest healthcare organization will decrease, which might increase the likelihood of an effective treatment since traveling is often seen as an energy consuming activity.

Furthermore, inclusion criteria for treating patients with CFS are well described in the trial. Using these criteria to refer patients will facilitate the process of referral to a rehabilitation centre. Diagnostic criteria and inclusion criteria should be introduced in different hospitals and in general practice centres to get more familiar with these criteria and facilitate the referral of the patients. This will also reduce the burden of the patients who are now sometimes referred to many different specialists in healthcare before arriving at the address where they can be effectively treated. Also the burden for the general practitioners will be reduced as nowadays they often see the patient repeatedly.

The above-mentioned products, services and processes are examples of how the scientific knowledge from this trial can be transferred and utilized in society. Focusing on two general aims: 1) Making treatment for patients with CFS as effective as possible and 2) making effective, evidence based treatment available to as many patients as possible. The patient should always be the starting point when decisions are to be made how to transfer knowledge into society.